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AUTHORIZATION TO DISCLOSE AND RECEIVE CLIENT HEALTH CARE INFOMATION

I hereby AUTHORIZE Victorious Images to release any clinical records needed to the insurance carrier (s) on file, to my referring doctor (s),

Dr. (s)_____

and to those listed below.

Victorious Images may RECEIVE medical records along with any other information deemed necessary from the same or any other medical/professional establishment for the purpose of filing my insurance claims.

_____ _____

It is my understanding this authorization will remain in effect until I cancel by written notice.

HIPPA/Supplier Standards and Medicare Supplier Standards Acknowledgement

I hereby acknowledge that I have been provided INFORMATION on where to locate Victorious Images' Notice of Privacy Practices and/or the Medicare Supplier Standards.

(www.victoriousimages.com)

_____ _____

Client Signature Date